Operational Efficiency Impact on Reimbursement

Arkansas CAH Administrators
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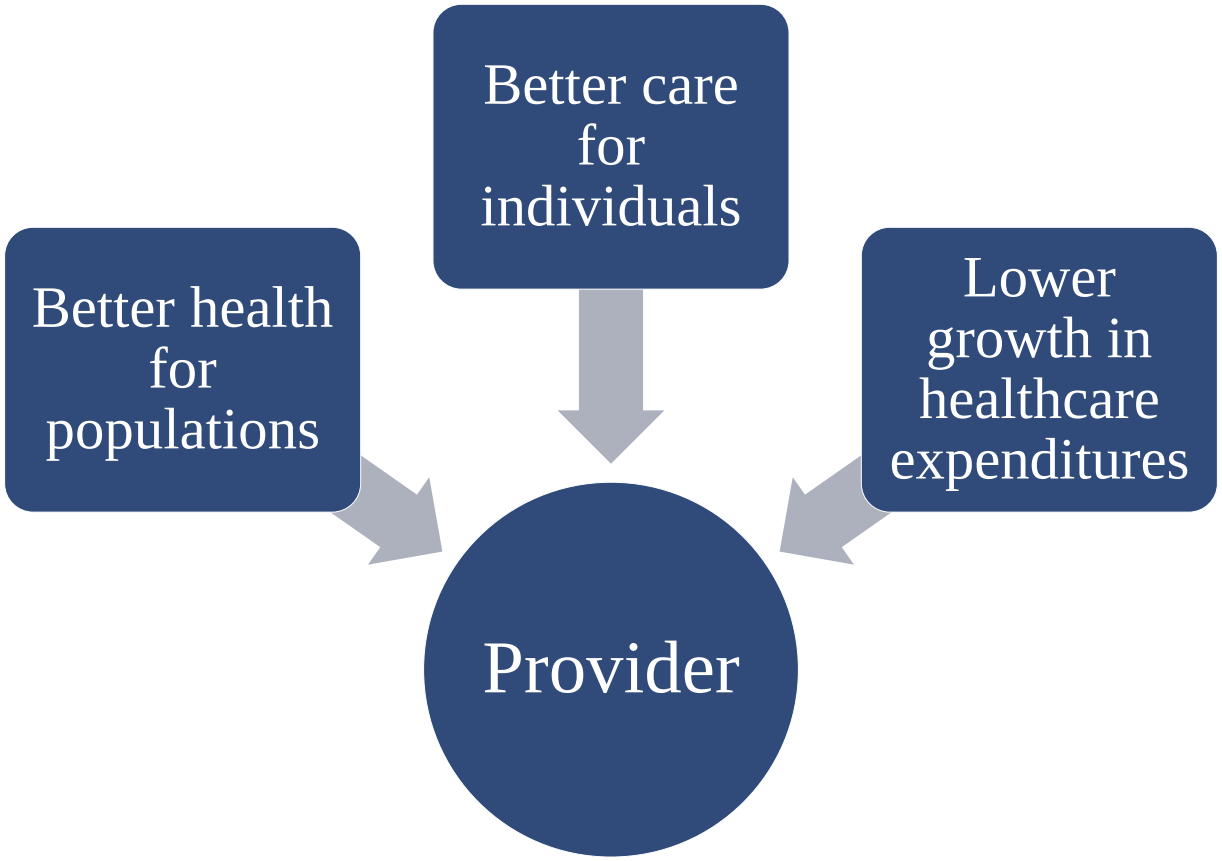
Agenda

- State of the Healthcare Industry
- The paradigm shift
- The importance of benchmarks
- Process challenges
- NRACO
- Questions

Health Care Reform

STATE OF HEALTHCARE INDUSTRY

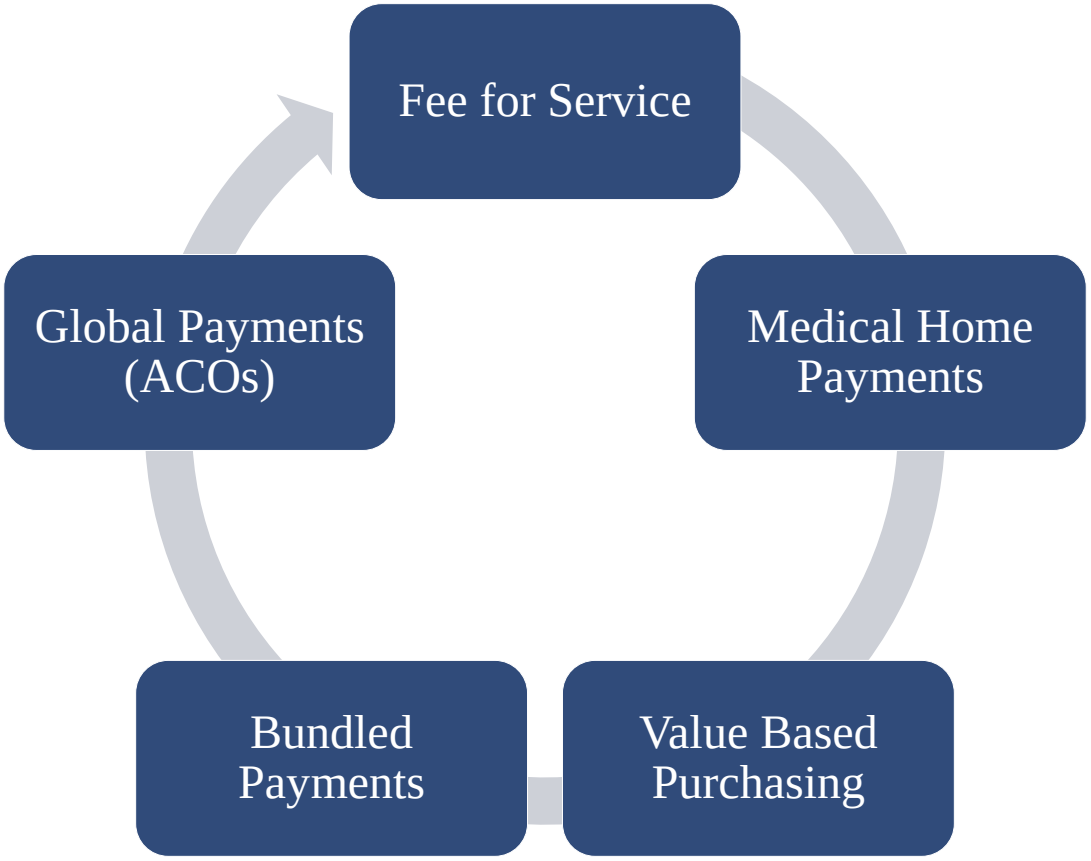
Healthcare Reform Aim



Challenges Facing Healthcare Providers

- **Providers currently experiencing significant financial challenges**
- **Payment reform driving changes.**
- **Volume to Value!**
  - Volume of services provided per patient will no longer be the way providers increase revenue.
  - Under the ACA, providers will be paid to keep patients healthy and out of the hospital.
  - This means you will need more patients to increase revenue overall, while keeping cost per patient (unit cost) low.

Payment Reform Driving Changes



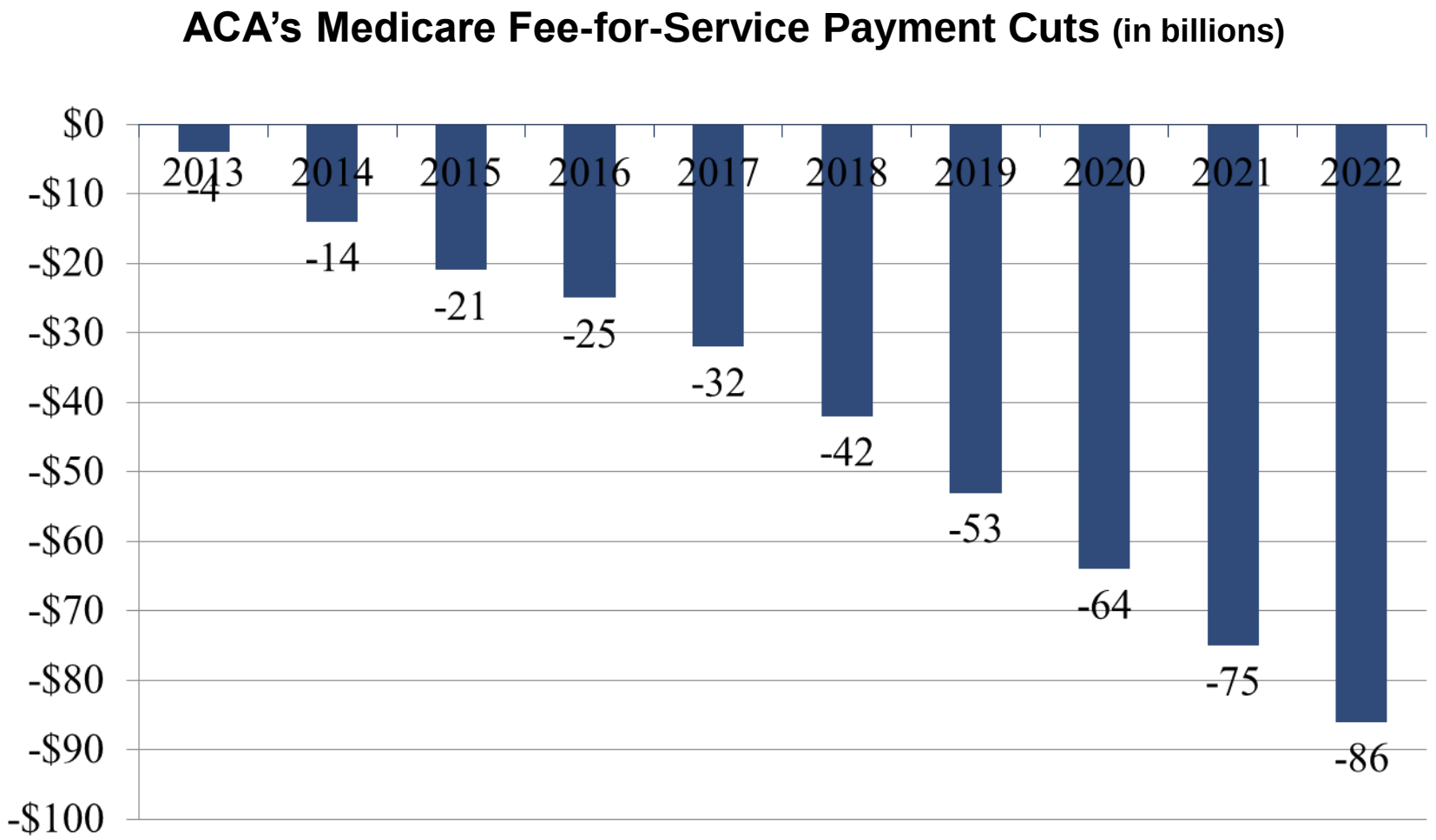
Special Challenges Facing CAHs

- **OIG Report on CAH Designation.**
  - The August 2013 report challenges the status of numerous CAHs who were waived into the program by their states prior to the waiver being disallowed.
  - More than 700 hospitals could close if they are required to reapply under the current CAH designation standards.
  - Note: Currently CAHs within 10 miles of another hospital are being scrutinized in legislation.

Special Challenges Facing CAHs

- **Anticipated OIG Report on Swing Beds.**
  - This report will most likely challenge whether CAHs will be able to maintain cost-reimbursement for these vital services.
- **Sequestration.**
  - This is ongoing and already taking 2% of Medicare revenue away from CAHs.
    - Note: The federal government is looking at reducing future Medicare spending in order to pay for non-health care related programs today. This could severely impact future reimbursement.

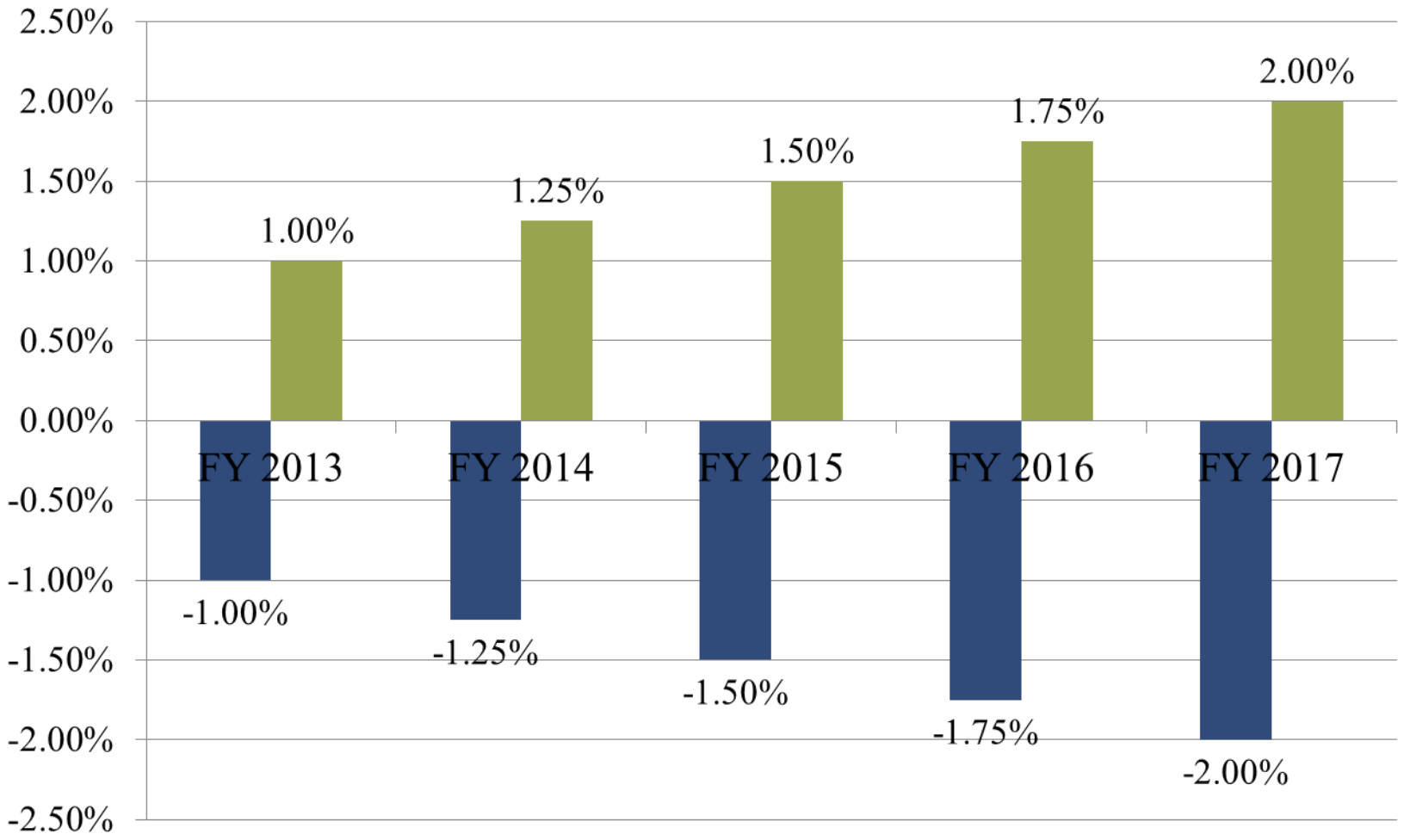
CMS targets reimbursement cuts



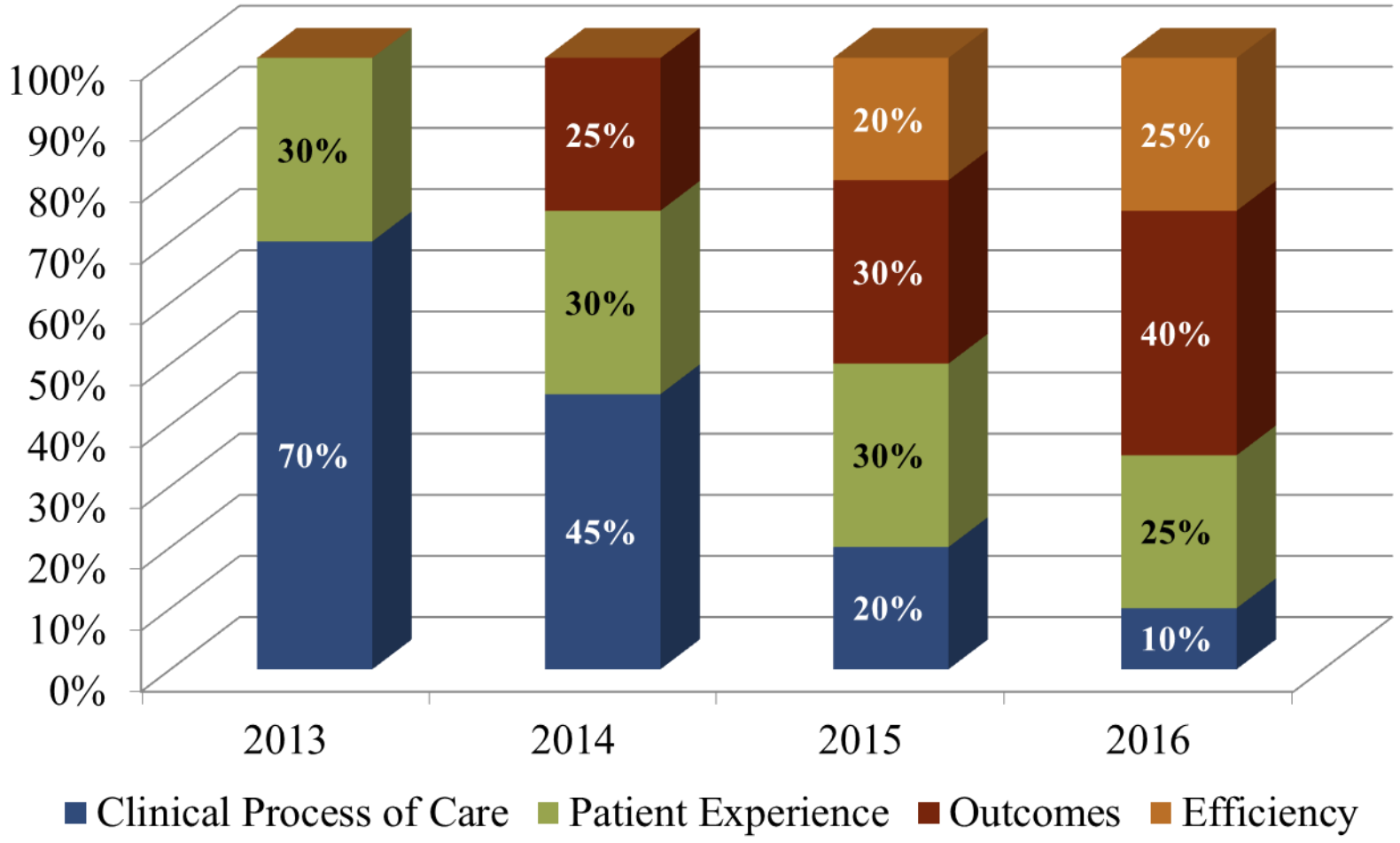
Challenges Facing Healthcare Providers

- **Value-based Purchasing.**
  - The ACA has already shifted reimbursement from “services provided” to “value provided” for PPS facilities.
  - It is expected that CAHs will also be required to make this shift. This will require CAHs to focus on value indicators, and implement quality and efficiency reporting.
  - Note: We believe there will be an efficiency factor in the future that will reward or penalize CAHs based on their evidenced efficiency.

Value Based Purchasing Reductions



Value Based Purchasing Domain Weighting



Challenges Facing Healthcare Providers

- **Readmissions penalty.**
  - PPS hospitals are already being penalized for readmissions.
  - While CAHs are still paid for readmissions today, this is anticipated to change as health care moves to a prevention mandate.
- **Hospital acquired conditions (HAC) penalty.**
  - Last program implemented from ACA's pay-for-performance initiative. Begins FFY 2015 (1% - estimated to impact 753 hospitals)

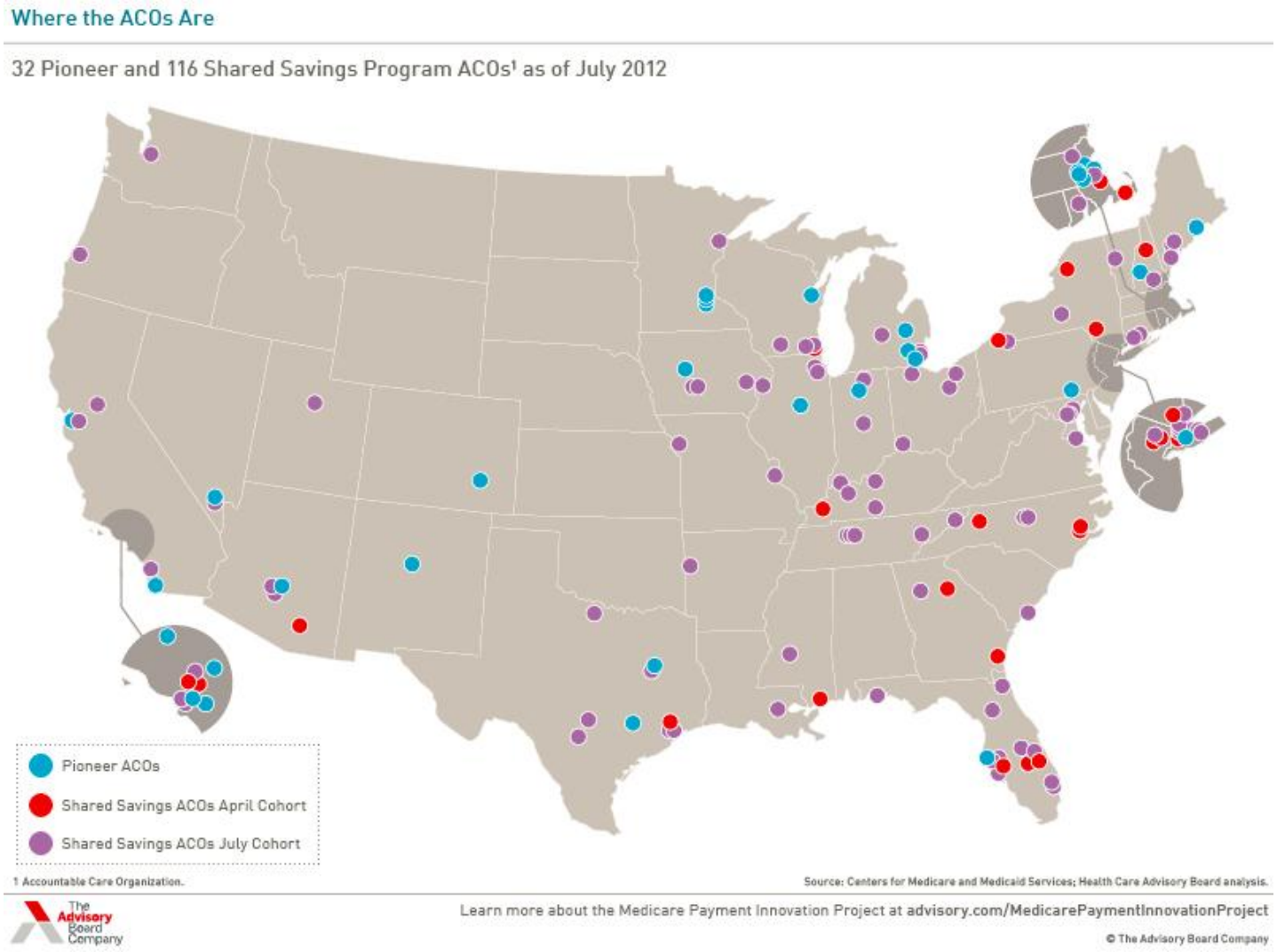
Challenges Facing Healthcare Providers

- **Narrow Networks.**
  - As providers examine their ability to serve their community, defining and participating in narrow networks is becoming a reality.
  - Challenges include how to determine whom to partner with, how to prove value/cost to the network and how to prevent the organization from being excluded from such networks.

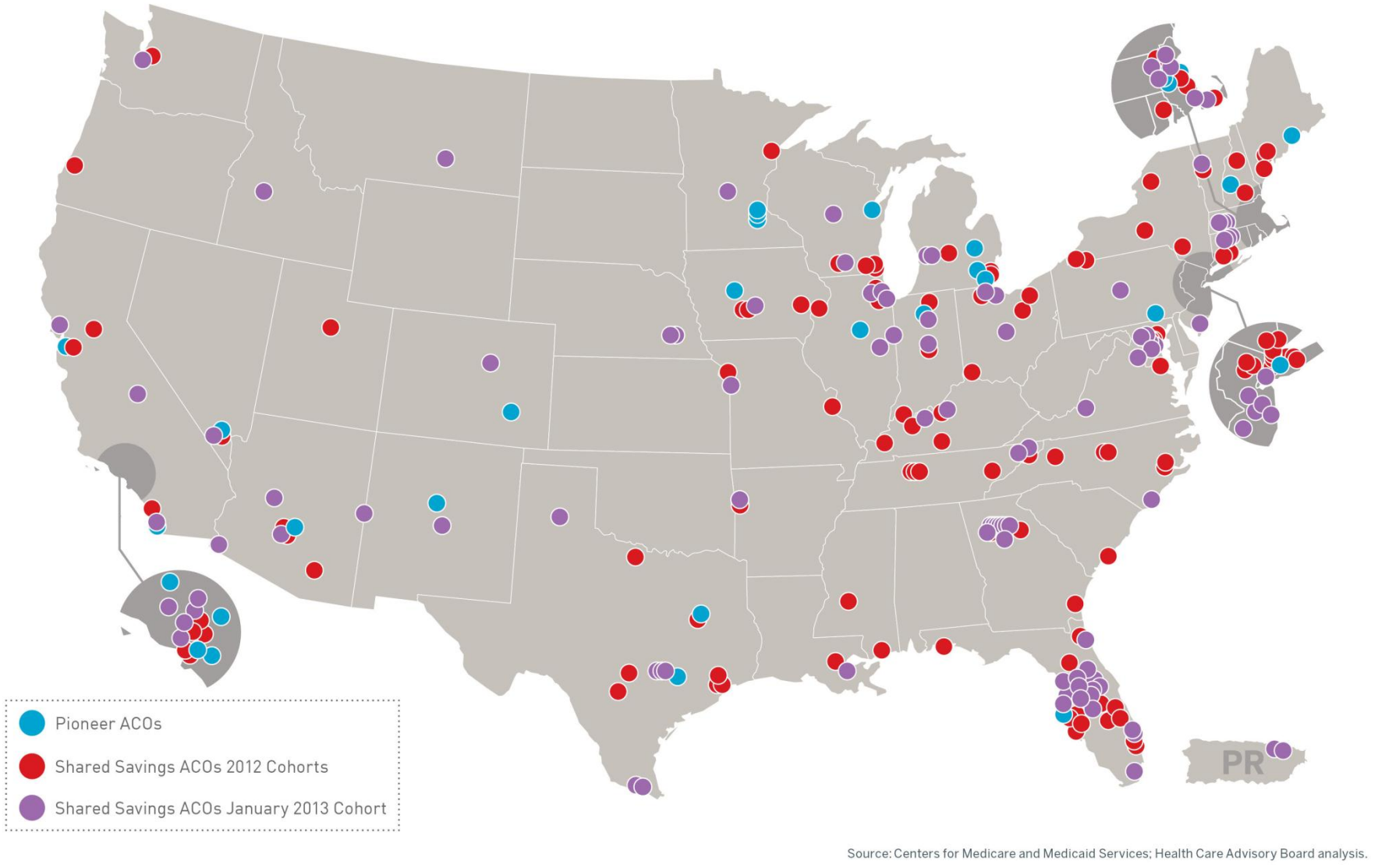
Challenges Facing CAHs

- **Affiliation Strategies.**
  - Providers (Including CAHs) will not be exempt from needing to determine whom they affiliate with and to what extent they maintain independence.
  - Having partners and ***integrating care across affiliations*** may very well become the status quo for CAHs of the future.

Medicare ACO's as of July 2012

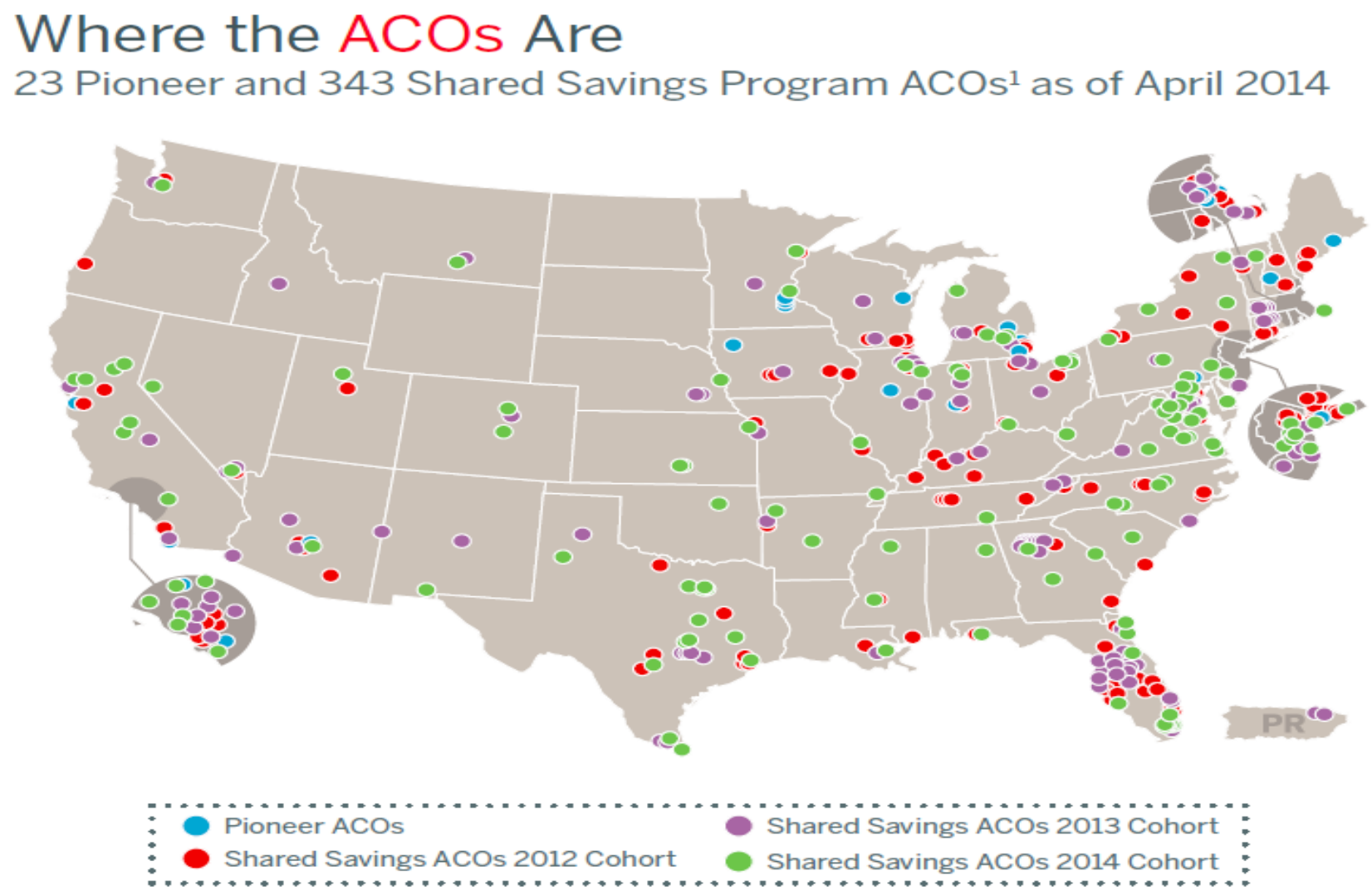


Medicare ACO's as of January 2013



Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board analysis.

Medicare ACO's as of April 2014



Source: The Advisory Board

Challenges Facing Healthcare Providers

- **Pricing Transparency.**
  - Increases in out-of-pocket deductibles and coinsurance are causing patients to shop and price compare for health care services.
    - CAH Coinsurance impacts
    - October 8th OIG report
  - Providers need to have transparent pricing and know how to demonstrate the value of their pricing to patients.

- **Bundled Payment Strategies?**

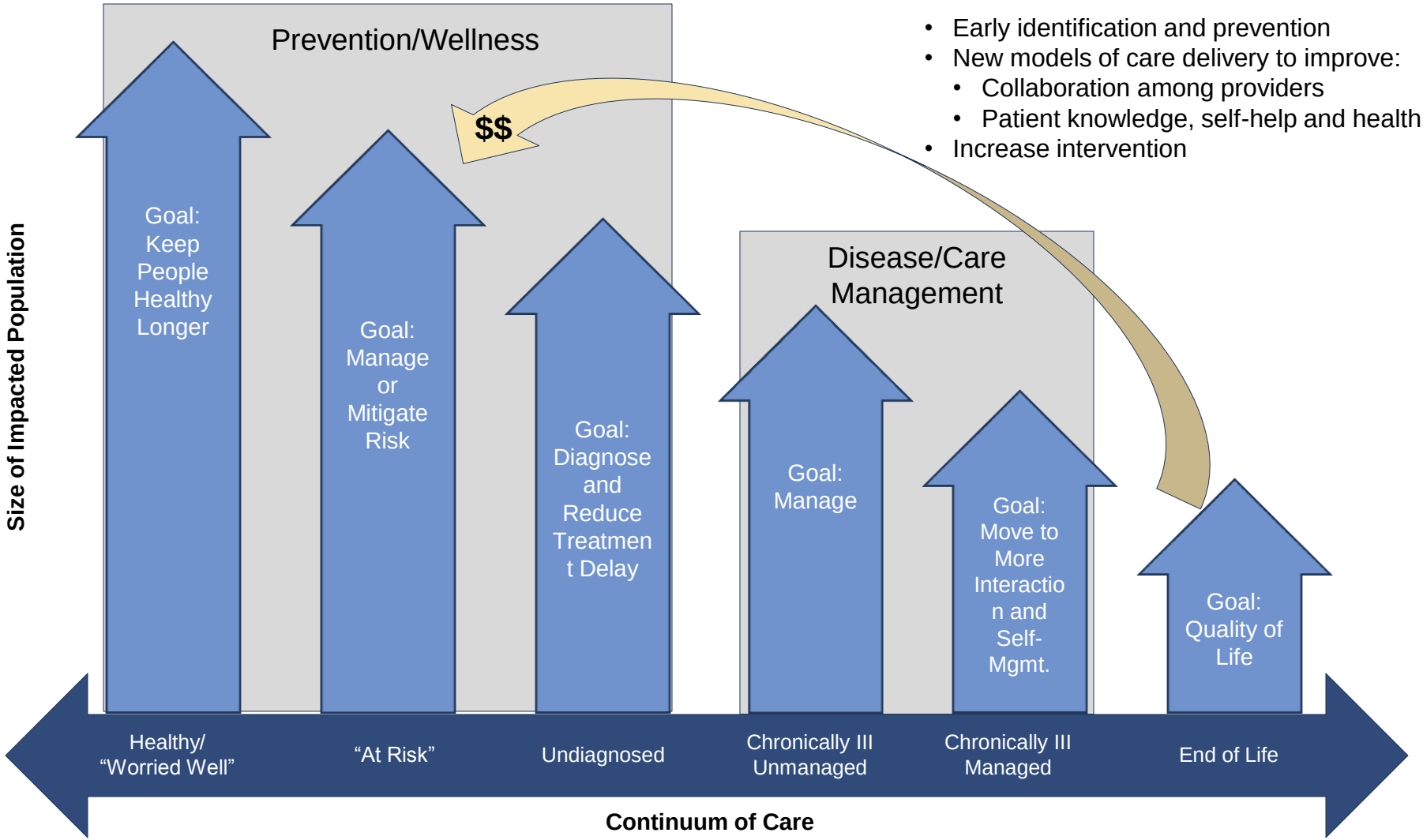
Challenges Facing Providers

- **Community Health Needs Assessment Results.**
  - As a current requirement of non-profit hospitals today, the data in this assessment is a crucial starting point to determine how your facility currently provides services and what the gaps are for care.
  - As the ACA moves care to a “predict and prevent” standard, hospitals will also be responsible for the health of populations and not just individual patients.

Challenges Facing Healthcare Providers

- **Delivery of Care Choices.**
  - Providers will need to carefully evaluate the needs of their community, their total cost of patient care, their affiliations, and all factors influencing their ability to deliver services and make choices about what services they can and should provide.

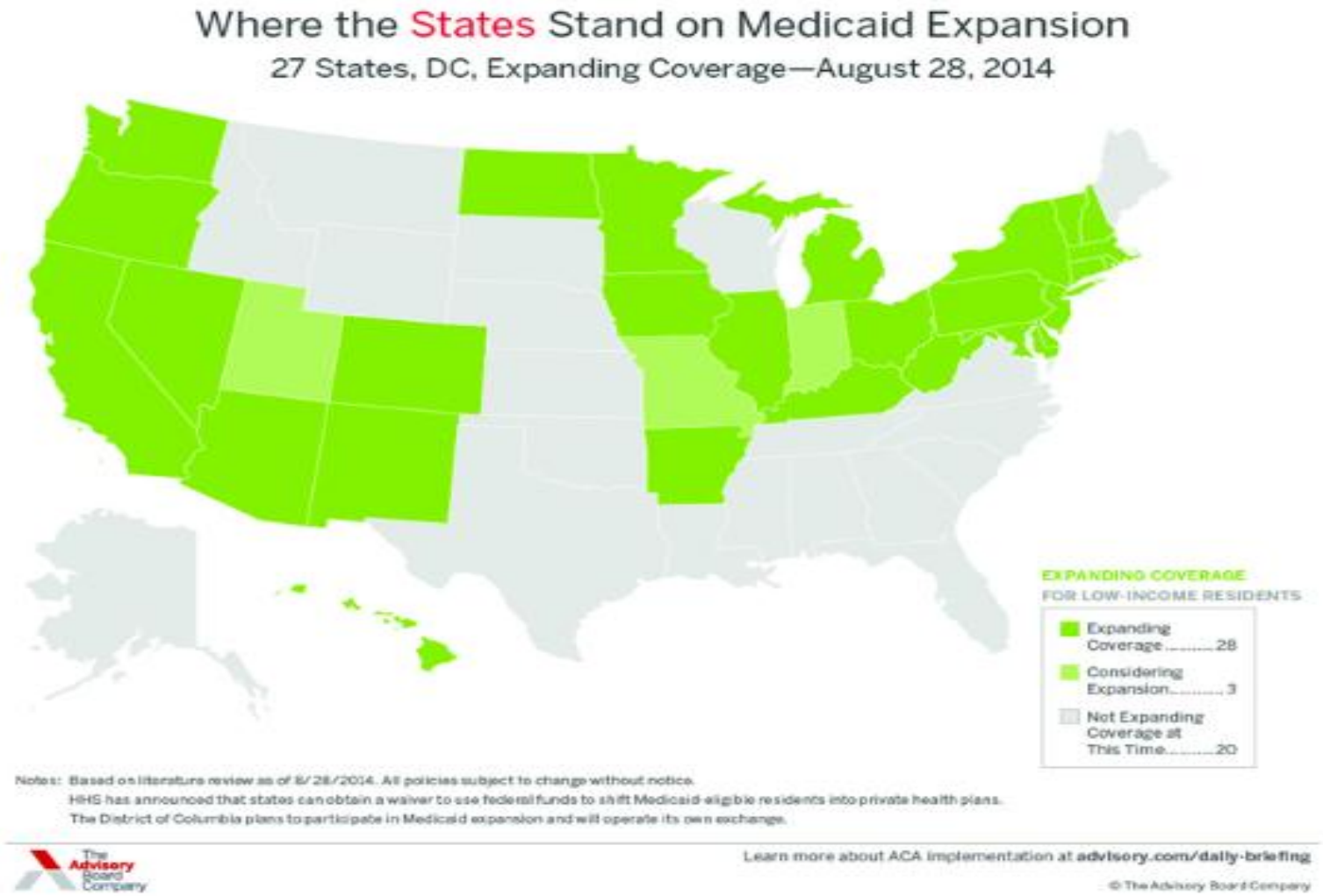
Care Delivery Transformation: From Acute Care to Prevention
Track, Predict, Intervene, Manage



- Early identification and prevention
- New models of care delivery to improve:
  - Collaboration among providers
  - Patient knowledge, self-help and health
- Increase intervention

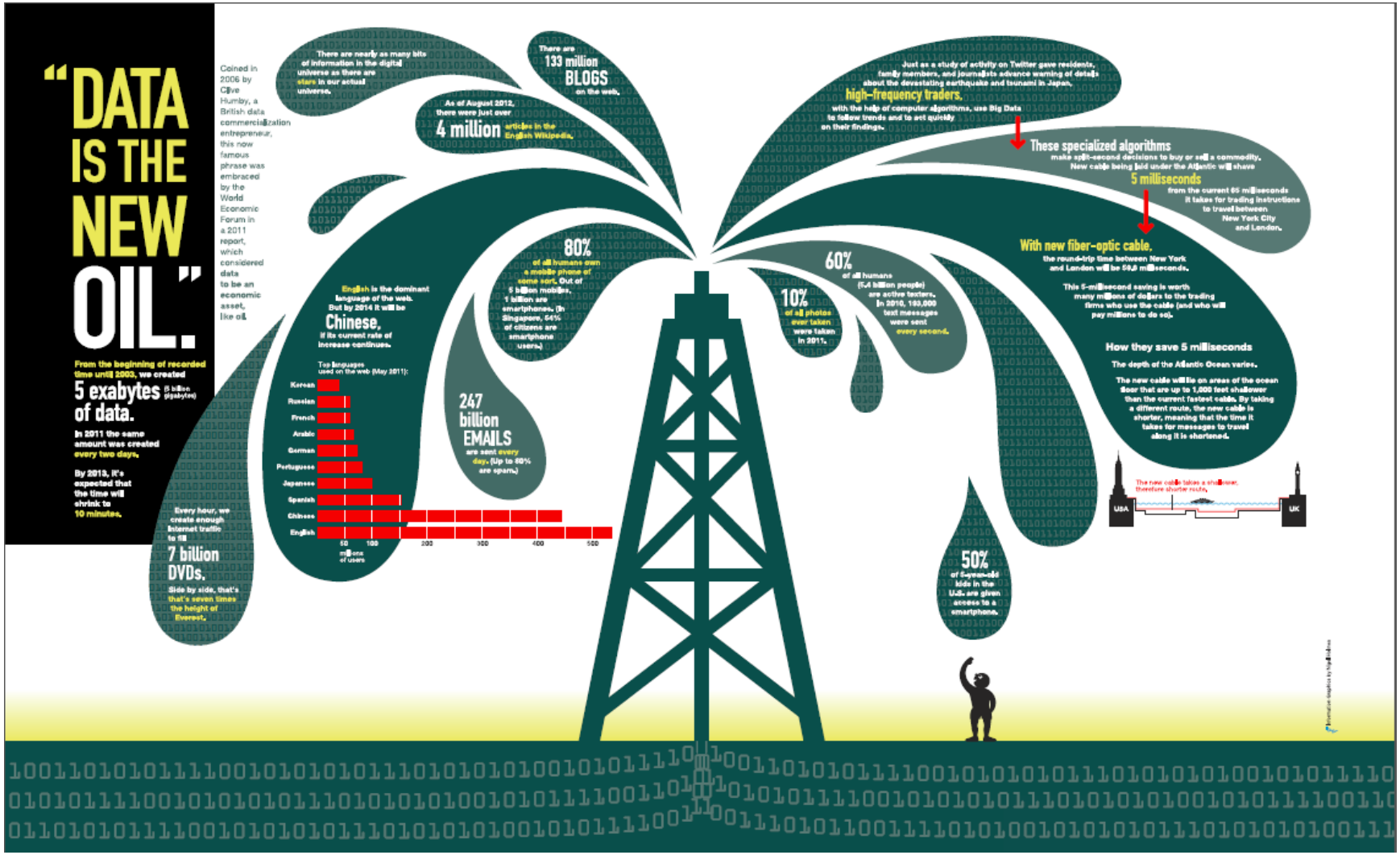
Source: *The Accountable Care Team* presentation – presented by: Greg Caressi, Frost & Sullivan; Jacquelyn Hunt, IHI Fellow Consultant; Sue Scanlin, Continuum Health; Steve Kupsky,

Medicaid Expansion



Disruptive - Technologies

Disruptive - Health Care Data



Challenges Facing Healthcare Providers

- **Data Analyses.**
  - The future of health care will be dependent upon the quality of data analyses that health care providers perform.
  - This means providers need to start looking at the data available to them, how to analyze it, and how to translate it into relevant actions to meet the “predict and prevent” mandate.

Moving Forward!

- In this era of health care, facilities must look at all areas of opportunities for financial improvement.
- This consists of looking at methods to:
  - Manage changing reimbursement,
  - Margin management - operational cost controls,
  - Add value – community and strategic!

Time to Innovate!

- The approach you have used in the past will no longer be what works in the future.
- Providers will be required to innovate with:
  - Technology, (tele-health, mobile/online care options),
  - Better training and development (Continuous Learning),
  - Value propositions (internal & external clients),
  - Accountability

Top 10 Issues from The Advisory Board

- Managing labor costs
- Managing FFS vs risk based revenue streams
- Understanding impact of policy changes on reimbursement
- Ensuring effective ICD 10 implementation
- Increasing CMI through improved clinical documentation
- Responding to future revenue cycle changes
- Optimizing the financial impact of case management
- Managing medical necessity for IP vs Observation
- Implementing effective clinical-finance partnerships
- Preventing prior authorization denials

Reimbursement Opportunities

- Often overlooked by providers
- Believe charges do not matter because Medicare, Medicaid, and some third-party payers reimburse on fee schedule
- Significant fluctuations in charges from provider to provider
  - Difficult to hold staff accountable if organization has not maintained proper price structure to ensure proper reimbursement for work already done
- Large difference in third party contract language by facility

Financial Modeling

	Current Arrangement				Model 1			
Payer	Gross Revenue	Mix %	Payment Level	Net Revenue	Gross Revenue	Mix %	Payment Level	Net Revenue
Medicare	3,500,000	35.0%	70.0%	2,450,000	3,500,000	35.0%	70.0%	2,450,000
Medicare Advantage	500,000	5.0%	70.0%	350,000	500,000	5.0%	70.0%	350,000
Blue Cross	2,000,000	20.0%	95.0%	1,900,000	1,800,000	18.0%	95.0%	1,710,000
Blue Cross PPO				-	-	0.0%		-
United Healthcare	1,000,000	10.0%	95.0%	950,000	900,000	9.0%	95.0%	855,000
United Healthcare PPO				-	-	0.0%		-
Other Commercials								
A	500,000	5.0%	100.0%	500,000	450,000	4.5%	100.0%	450,000
B			100.0%	-	-	0.0%	50.0%	-
C			100.0%	-	-	0.0%	100.0%	-
D			100.0%	-	-	0.0%	100.0%	-
Medicaid	1,000,000	10.0%	60.0%	600,000	1,000,000	10.0%	60.0%	600,000
Medicaid Exchange			60.0%	-	350,000	3.5%	60.0%	210,000
Self Pay	1,500,000	15.0%	25.0%	375,000	1,500,000	15.0%	25.0%	375,000
	10,000,000	100.0%	71.3%	7,125,000	10,000,000	100.0%	70.0%	7,000,000
					Difference from Current			(125,000)

10% of commercial are eligible and Switch to Medicaid on Exchange

Financial Modeling

	Model 2				Model 3			
Payer	Gross Revenue	Mix %	Payment Level	Net Revenue	Gross Revenue	Mix %	Payment Level	Net Revenue
Medicare	3,500,000	35.0%	70.0%	2,450,000	3,500,000	35.0%	70.0%	2,450,000
Medicare Advantage	500,000	5.0%	70.0%	350,000	500,000	5.0%	70.0%	350,000
Blue Cross	1,500,000	15.0%	95.0%	1,425,000	2,000,000	20.0%	95.0%	1,900,000
Blue Cross PPO	500,000	5.0%	80.0%	400,000	-	0.0%	80.0%	-
United Healthcare	750,000	7.5%	95.0%	712,500	1,000,000	10.0%	95.0%	950,000
United Healthcare PPO	250,000	2.5%	80.0%	200,000	-	0.0%	80.0%	-
Other Commercials								
A	375,000	3.8%	100.0%	375,000	500,000	5.0%	100.0%	500,000
B	125,000	1.3%	50.0%	62,500	-	0.0%	50.0%	-
C	-	0.0%	100.0%	-	-	0.0%	100.0%	-
D	-	0.0%	100.0%	-	-	0.0%	100.0%	-
Medicaid	1,000,000	10.0%	60.0%	600,000	1,000,000	10.0%	60.0%	600,000
Medicaid Exchange	-	0.0%	60.0%	-	750,000	7.5%	60.0%	450,000
Self Pay	1,500,000	15.0%	25.0%	375,000	750,000	7.5%	25.0%	187,500
	10,000,000	100.0%	69.5%	6,950,000	10,000,000	100.0%	73.9%	7,387,500
	Difference from Current			(175,000)	Difference from Current			262,500

25% shift from major commercial to a PPO with larger discounting.

50% shift of self pay to Medicaid on the Exchange.

Margin Management: Expense Breakdown

Expense Breakdown Averages:

Salaries, wages & benefits	45% to 60%
Supplies	15% to 22%
Purchased services	10% to 15%
Professional fees	5% to 7%
Depreciation	6% to 8%
Interest	5% to 8%
Bad debts	2% to 4%
Other	5% to 7%

Traditional Approach to Margin Management (Cost Control)

- Isolated cost control campaigns
  - Across the organization cuts
  - High profile positions
  - Ready; Fire; Aim!!
- Little understanding of true costs
- Lack of buy in by clinical staff to cost control initiative

- **Bottom line**
  - Decisions have been made at an Administrative level and Staff are told to implement the plan!

Traditional Approach to Margin Management (Cost Control)

- Typically, this results in:
  - "This can't be done."
  - "We are already overworked."
  - "*They* don't know what we do."
  - "Patients will die."
  - "This is how we've always done it."
- Staff threaten to quit
- Administration must increase salaries in order to retain staff
- This creates more expense versus less

Paradigm Shift – A New Way!

- Productivity targets – leader driven;
- Transform to a permanent approach to transformational cost control;
- Improved analytics on cost and productivity;
- Collaboration gains – clinicians are on board!

Benchmarks/Productivity Metrics

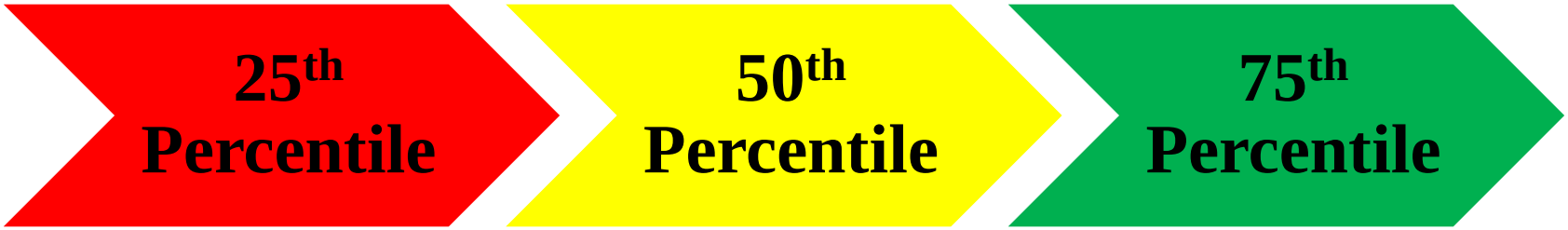
- Benchmarks provide guidance as to the recommended or normal staffing levels of individual departments
  - Facility must maintain necessary statistical information
  - Staff must understand the benchmark metric

Benchmarks

- Used alone, benchmarks can result in decisions that are not realistic
  - Not just a number used to reduce staff
- Benchmarks assume an ability to gather data consistently
- Benchmarks often contain a large range or assume all organizations are the same
  - Must assure “apples to apples” comparison
- The changing environment is resulting in lower benchmarks in many departments

Benchmarks

- Benchmarks are ***NOT*** averages
- Benchmarks ***ARE*** best practices



Departmental Productivity – Med/Surg

	2012	2013	2014
Dept worked hrs	86,900	87,100	83,000
Total # Med Surg/SB pat. days	4,600	5,100	4,600
Hrs per Patient Day	18.89	17.08	18.04
Benchmark	**8.50**	**8.50**	**8.50**
Hrs ovr Benchmark	47,800	43,750	43,900
Savings if achieve Benchmark	**$1,434,000**	**$1,312,000**	**$1,317,000**

Departmental Productivity - ER

	2012	2013	2014
Dept worked hrs	40,000	46,000	50,000
Total # of ER visits	13,500	14,000	14,700
Hrs per ER visit	2.96	3.29	3.40
Benchmark	**2.20**	**2.20**	**2.20**
Hrs ovr Benchmark	10,300	15,200	17,660
Savings if achieve Benchmark	**$309,000**	**$456,000**	**$529,800**

Be the “Rightsize”!

Work Smarter – Not Harder!

Review of Processes

- Need to individualize to each department in each facility
  - What types of patients on each unit?
  - Where is the work done?
  - How is the work done?
  - Who is doing the work?

Departmental Issues

- Staff mix
- Facility layout
- Staffing patterns
- Managing “extra minutes”
- Miscellaneous

Process Improvement

- **NEVER** accept “this is the way it has always been done”
- Challenge employees
  - Ask “why, why, why…”
- Eliminate organizational barriers
  - Don’t over-direct, over-observe, over-report
  - Reward flexibility
  - Remove policy barriers
  - Identify hidden agendas

Process Improvement

- Avoid “analysis paralysis”
- Don’t worry about “being right”
  - You can’t anticipate all the possible issues that might arise
  - Just anticipate what you’ll do if a problem arises
- Once you’ve made a decision, stand by it
  - Make changes to the process, not the intended outcome

Definition of Insanity?

“If *you always do what you’ve always done, you’ll get what you’ve always gotten.”*

Workforce Management Strategy

Develop Productivity Metrics

- 6 months
- 12 months
- 18 months

Infrastructure development

- Process improvement
- Understand changing market demographics
- Right skills mix

Accountability

- Ongoing monitoring
- Departmental collaboration

How will this impact my reimbursement??

- This is a frequent question from CAH providers
- Concerns that efficiencies will lead to lower reimbursement

How will this impact my reimbursement??

- Reality – steps to improve care coordination and improve efficiencies may result in lower revenues from some payers

How will this impact my reimbursement??

- CAH
  - No impact on prospective payors payment for services
    - Many Commercials
    - Medicare prospective services
      - Skilled Nursing Home
      - Physician Fee Schedule
      - Home Health
      - Hospice
    - May see some volume of service reductions

How will this impact my reimbursement??

- CAH
  - Potential impacts
    - Medicare cost based reimbursement
    - Reductions from charge based payors could be experienced due to reductions in length of stay and reduced utilization of billable services
  - Important Message
    - Decreases in CAH reimbursement from Medicare due to cost reductions will typically be substantially less than the cost savings.
    - Improved efficiencies improves profitability of services provided to other payors.

It is about when, not if

- Cost reductions will become a reality in the future.
- Those that implement cost savings the earliest will create the greatest advantages.
- There has never been a more important time than now to challenge the status quo.

Questions?

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